



California Performance Review

Comments and Testimony

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We appreciate the opportunity to comment on the California Performance Review recommendations. We have some specific comments, however, we feel we cannot make significant contributions to the feedback process without considerably more information on the specifics of the proposed recommendations. In addition, the tight timeline has not allowed for a process of thoughtful engagement with our partners on the issues raised by the report.

Finally, and most importantly, although we agree that ‘streamlining’ and ensuring that government agencies are structured--and services provided--in the most efficient manner possible, we do not believe that the fundamental barriers to improving the health of California’s communities of color are addressed in the CPR report or its recommendations. Eliminating racial and ethnic health disparities requires seamless access to insurance coverage and care, better data collection by state agencies and health care institutions, a commitment to delivering care in a culturally and linguistically appropriate manner, and addressing community factors such as the lack of access to quality foods, safe walkways, housing and transportation. We believe that an infusion of additional revenues from progressive taxes is the only way to address the state’s fiscal health in the long term, and that the transition costs associated with the CPR recommendations would be better spent on addressing these unmet needs.

Comments to Specific Recommendations:

Reorganization: Department of Health and Human Services

We have several concerns with placing DMHC, and the administration of the Medi-Cal and Healthy Families Programs into a Center for Health Purchasing and a Quality Assurance Division. Currently, the existence of an independent DMHC, Office of the Patient Advocate (OPA), and Managed Risk Medical Insurance Board (MRMIB) have allowed the community to make significant gains in terms of services. The independent MRMIB has followed a transparent process with open meetings, and the MRMIB staff has undertaken projects to improve the quality of health plan services. DMHC and OPA have spearheaded work on improving HMO quality and have improved the provision of cultural and linguistic services provided by health plans through reports cards and regulatory requirements. We are concerned that operations assigned under a ‘purchasing center’ will not have the consumer focus in mind. Staff may view their job as simply to maximize services bought by the state at the lowest possible price. We are also concerned about the functions of the Quality Assurance Division, and how much power staff will have to conduct effective audits. We are also concerned that DMHC and OPA are funded through fees assessed on health plans, and we believe this independent revenue stream must not be tampered with.

We also have concerns about the elimination of other bodies that have targeted functions, such as the Rural Health Policy Council, Commission on Asian and Pacific Islander American Affairs,

Health Policy and Data Advisory Commission, and the DMHC Committee. These bodies are important sources of community input. We also are not clear as to the fate of other bodies and offices that are important to community health, such as the Office of Multicultural Health and the Council on Multicultural Health. Offices, task forces, and councils with specific functions and mechanisms for community input are essential to ensuring the provision of quality health services and for securing the public's health.

HHS01 Transform Eligibility Processing

We do not necessarily agree that the current eligibility process is as inefficient and inaccurate as the CPR report asserts, however we do believe improvements can be made. The concept of aligning eligibility for Medi-Cal, CalWORKs, and Food Stamps is intriguing, but it would be essential that no one who is currently eligible for any of the three programs be rendered ineligible by any change of eligibility status. We do strongly support the elimination of the current assets test. We do support more funding for outreach and eligibility workers to help applicants complete the process, however again more detail is necessary to adequately address the proposal. For example, what kinds of training would be required for outreach workers and is the assistance fee the state would pay sufficient? Enhanced use of the internet for submitting applications can be problematic, as there is a continued 'digital divide' that may prevent rural and low-income individuals from accessing the programs effectively. Finally, we need more fully to explore the ramifications of turning over local functions to the state.

HHS23 Streamline Oversight Requirements for Conducting Medical Survey/Audits of Health Plans

We have strong concerns with this provision. CPEHN and partner advocates have been extremely successful in the past several years in securing requirements for the provision of culturally and linguistically appropriate services by health plans. In order to ensure compliance with these requirements, extensive monitoring by the Department of Health Services and DMHC is required. Strong auditing is the only way to ensure communities of color are protected and their rights to receive quality health care secured.

HHS28 Improve Integrity in Medi-Cal Through the Use of Smart Cards

We have concerns that requiring Medi-Cal beneficiaries to be fingerprinted will prove a barrier to individuals seeking services or having services rendered. We are also concerned about the impact on small, culturally competent providers at having to assess the smart cards of persons seeking services.